CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Program Quality and Outcomes
(Amendment)

907 KAR 17:010. Managed care organization requirements and policies relating to enrollees.

RELATES TO: KRS Chapter 13B, 194A.025(3), 205.624, 311.621-311.643, 387.500-387.800, 42 U.S.C. 1396a, 1396n, 1396u-2, 42 C.F.R. 422.112, 422.113, 431.51, 431.200-431.250, 433.138, Part 438, 45 C.F.R. 233.100

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.025(3), 194A.030(2), 194A.050(1), 205.520(3), 205.560, 42 U.S.C. 1396n(b), 42 C.F.R. Part 438

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the managed care organization requirements and policies relating to individuals enrolled with a Medicaid managed care organization.

Section 1. Enrollment of Medicaid or KCHIP Recipients into Managed Care. (1) Except as provided in subsection (3) of this section, enrollment into a managed care organization shall be mandatory for a Medicaid or KCHIP recipient.

(2) The provisions in this administrative regulation shall be applicable to a:

(a) Medicaid recipient; or

(b) KCHIP recipient.

(3) The following recipients shall not be required to enroll, and shall not enroll, into a managed care organization:

(a) A recipient who resides in:

1. A nursing facility for more than thirty (30) calendar days; or

2. An intermediate care facility for individuals with an intellectual disability; or

(b) A recipient who is:

1. Determined to be eligible for Medicaid benefits due to a nursing facility admission;

2. Receiving:

a. Services through the breast and cervical cancer program pursuant to 907 KAR 20:055;

b. Medicaid benefits in accordance with the spend-down policies established in 907 KAR 20:020;

c. Services through a 1915(c) home and community based services waiver program; <u>or</u>

d. Hospice services in a nursing facility or intermediate care facility for individuals with an intellectual disability; [~~or~~

~~e. Medicaid benefits as a Medicaid Works individual;~~]

3. A Qualified Medicare beneficiary who is not otherwise eligible for Medicaid benefits;

4. A specified low-income Medicare beneficiary who is not otherwise eligible for Medicaid benefits;

5. A Medicare qualified individual group 1 (QI-1) individual;

6. A qualified disabled and working individual;

7. A qualified alien eligible for Medicaid benefits for a limited period of time; or

8. A nonqualified alien eligible for Medicaid benefits for a limited period of time.

(4)(a) The department shall assign a recipient to an MCO based upon an algorithm that considers:

1. Continuity of care; and

2. Enrollee preference of an MCO provider.

(b) An assignment shall focus on a need of a child or an individual with a special health care need.

(5)(a) A newly eligible recipient or a recipient who has had a break in eligibility of greater than two (2) months shall have an opportunity to choose an MCO during the eligibility application process.

(b) If a recipient does not choose an MCO during the eligibility application process, the department shall assign the recipient to an MCO in accordance with subsections (4) and (6) of this section.

(6) Each member of a household shall be assigned to the same MCO.

(7) The effective date of enrollment for a recipient described in subsection (5) of this section shall be the date of Medicaid eligibility.

(8) A recipient shall be given a choice of MCOs.

(9) A recipient enrolled with an MCO who loses Medicaid eligibility for less than two (2) months shall be automatically reenrolled with the same MCO upon redetermination of Medicaid eligibility.

(10) A newborn who has been deemed eligible for Medicaid shall be automatically enrolled with the newborn's mother's MCO as an individual enrollee for up to sixty (60) calendar days.

(11)(a) An enrollee may change an MCO for any reason, regardless of whether the MCO was selected by the enrollee or assigned by the department:

1. Within ninety (90) calendar days of the effective date of enrollment;

2. Annually during an open enrollment period;

3. Upon automatic enrollment under subsection (9) of this section, if a temporary loss of Medicaid eligibility caused the recipient to miss the annual opportunity in subparagraph 2. of this paragraph; or

4. When the Commonwealth of Kentucky imposes an intermediate sanction specified in 42 C.F.R. 438.702(a)(3).

(b) An MCO shall accept an enrollee who changes MCOs under this section.

(12) Only the department may enroll a Medicaid recipient with an MCO in accordance with this section.

(13) Upon enrollment with an MCO, an enrollee shall receive an identification card issued by the MCO.

(14)(a) Within five (5) business days after receipt of notification of a new enrollee, an MCO shall send, by a method that shall not take more than three (3) calendar days to reach the enrollee, a confirmation letter to an enrollee.

(b) The confirmation letter shall include at least the following information:

1. The effective date of enrollment;

2. The name, location, and contact information of the PCP;

3. How to obtain a referral;

4. Care coordination;

5. The benefits of preventive health care;

6. The enrollee identification card;

7. A member handbook; and

8. A list of covered services.

(15) Enrollment with an MCO shall be without restriction.

(16) An MCO shall:

(a) Have continuous open enrollment for new enrollees; and

(b) Accept enrollees regardless of overall enrollment.

(17)(a) Except as provided in paragraphs (b) through (e) of this subsection, a recipient eligible to enroll with an MCO shall be enrolled beginning with the first day of the month that the enrollee applied for Medicaid.

(b) A newborn shall be enrolled beginning with the newborn's date of birth.

(c) An unemployed parent shall be enrolled beginning with the date the unemployed parent met the definition of unemployment in accordance with 45 C.F.R. 233.100.

(d)1. Except as provided in paragraph (e) of this subsection, if an enrollee is retroactively determined eligible for Medicaid, the retroactive eligibility shall be for a period up to three (3) months prior to the month that the enrollee applied for Medicaid.

2. An MCO shall be responsible for reimbursing for covered services provided to a retroactively determined eligible individual referenced in subparagraph 1. of this paragraph during the individual's retroactive eligibility period.

(e) If an enrollee is retroactively determined eligible for Medicaid as a result of being determined retroactively eligible for SSI benefits:

1. The individual's enrollment date with an MCO shall be the first of the month following the month in which the department is notified of the individual's retroactive eligibility for SSI benefits; and

2. The department shall be responsible for reimbursing for any services provided during the retroactive eligibility period for an individual determined to be retroactively eligible for SSI benefits.

(18) For an enrollee whose eligibility resulted from a successful appeal of a denial of eligibility, the enrollment period shall begin:

(a) On the first day of the month of the original application for eligibility; or

(b) On the first day of the month of retroactive eligibility as referenced in subsection (17)(d) or (e) of this section, if applicable.

(19) A provider shall be responsible for verifying an individual's eligibility for Medicaid and enrollment in a managed care organization when providing a service.

Section 2. Disenrollment. (1) The policies established in 42 C.F.R. 438.56 shall apply to an MCO.

(2) Only the department may disenroll a recipient from an MCO.

(3) A disenrollment of a recipient from an MCO shall occur:

(a) If the enrollee:

1. Becomes incarcerated or deceased; or

2. Is exempt from managed care enrollment in accordance with Section 1(3) of this administrative regulation; or

(b) In accordance with 42 C.F.R. 438.56.

(4) An MCO may recommend to the department that an enrollee be disenrolled if the enrollee:

(a) Is found guilty of fraud in a court of law or administratively determined to have committed fraud related to the Medicaid Program;

(b) Is abusive or threatening but not for uncooperative or disruptive behavior resulting from his or her special needs (except if his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees) pursuant to 42 C.F.R. 438.56(b)(2); or

(c) Becomes deceased.

(5) An enrollee shall not be disenrolled by the department, nor shall the managed care organization recommend disenrollment of an enrollee, due to an adverse change in the enrollee's health.

(6)(a) An approved disenrollment shall be effective no later than the first day of the second month following the month the enrollee or the MCO files a request in accordance with 42 C.F.R. 438.56(e)(1).

(b) If the department fails to make a determination within the timeframe specified in paragraph (a) of this subsection, the disenrollment shall be considered approved in accordance with 42 C.F.R. 438.56(e)(2).

(7) If an enrollee is disenrolled from an MCO, the:

(a) Enrollee shall be enrolled with a new MCO if the enrollee is:

1. Eligible for Medicaid; and

2. Not excluded from managed care participation; and

(b) MCO shall:

1. Assist in the selection of a new primary care provider, if requested;

2. Cooperate with the new primary care provider in transitioning the enrollee's care; and

3. Make the enrollee's medical record available to the new primary care provider in accordance with state and federal law.

(8) An MCO shall notify the department or Social Security Administration in an enrollee's county of residence within five (5) working days of receiving notice of the death of an enrollee.

Section 3. Enrollee Rights and Responsibilities. An MCO shall have written policies and procedures to protect the rights of an enrollee that meets the information requirements established in 42 C.F.R. 438.10.

Section 4. MCO Internal Appeal Process. (1) An enrollee may file a grievance orally or in writing with the MCO at any time.

(a) Within five (5) working days of receipt of a grievance, an MCO shall provide the enrollee with written notice that the grievance has been received and the expected date of its resolution.

(b) An investigation and final resolution of a grievance shall:

1. Be completed within thirty (30) calendar days of the date the grievance is received by the MCO; and

2. Include a resolution letter to the enrollee that shall include:

a. All information considered in investigating the grievance;

b. Findings and conclusions based on the investigation; and

c. The disposition of the grievance.

(2) An MCO shall have an internal appeal process in place that allows an enrollee to challenge a denial of coverage of, or payment for, a service in accordance with 42 C.F.R. 438.400 through 438.424 and 42 U.S.C. 1396u-2(b)(4).

(3)(a) A provider shall not be an authorized representative of an enrollee without the enrollee's written consent for the specific action that is being appealed or that is the subject of a state fair hearing.

(b)1. For authorized representative purposes, written consent unique to an appeal or state fair hearing shall be required for the appeal or state fair hearing.

2. A single written consent shall not qualify as written consent for more than one (1):

a. Hospital admission;

b. Physician or other provider visit; or

c. Treatment plan.

(4) A legal guardian of an enrollee who is a minor or an incapacitated adult or an authorized representative of an enrollee in accordance with subsection (3) of this section may file an appeal on behalf of the enrollee.

(5) An enrollee shall have sixty (60) calendar days from the date of receiving a notice of adverse action from an MCO to file an appeal either orally or in writing with the MCO.

(6) An MCO shall resolve an appeal within thirty (30) calendar days from the date the initial oral or written appeal is received by the MCO.

(7) An MCO shall have a process in place that ensures that an oral or written inquiry from an enrollee seeking to appeal an adverse action is treated as an appeal to establish the earliest possible filing date for the appeal.

(8) An oral appeal shall be followed by a written appeal that is signed by the enrollee or an individual listed in subsection (4) of this section within ten (10) calendar days.

(9)(a) Within five (5) working days of receipt of an appeal, an MCO shall provide the enrollee with written notice that the appeal has been received and the expected date of its resolution. A copy of this information shall also be sent to an individual listed in subsection (4) of this section, if applicable.

(b) An MCO shall confirm in writing receipt of an oral appeal unless an expedited resolution has been requested.

(10) An MCO shall extend the thirty (30) day timeframe for resolution of an appeal established in subsection (6) of this section by fourteen (14) calendar days if:

(a) The enrollee requests the extension; or

(b)1. The MCO demonstrates to the department that there is need for additional information; and

2. The extension is in the enrollee's interest.

(11) For an extension requested by an MCO, the MCO shall give the enrollee written notice of the extension and the reason for the extension within two (2) working days of the decision to extend.

(12)(a) For an appeal, an MCO shall provide written notice of its decision within thirty (30) calendar days to an enrollee or a provider, if the provider filed the appeal.

(b) The provider shall:

1. Give a copy of the notice to the enrollee; or

2. Inform the enrollee of the provisions of the notice.

(13) An MCO shall:

(a) Continue to provide benefits to an enrollee, if the enrollee requested a continuation of benefits, until one (1) of the following occurs:

1. The enrollee withdraws the appeal;

2. Fourteen (14) calendar days have passed since the date of the resolution letter, if the resolution of the appeal was against the enrollee and the enrollee has not requested a state fair hearing or taken any further action; or

3. A state fair hearing decision adverse to the enrollee has been issued;

(b) Have an expedited review process for appeals if the MCO determines that allowing the time for a standard resolution could seriously jeopardize an enrollee's life or health or ability to attain, maintain, or regain maximum function;

(c) Resolve an expedited appeal within three (3) working days of receipt of the request; and

(d) Extend the timeframe for an expedited appeal established in paragraph (c) of this subsection by up to fourteen (14) calendar days if:

1. The enrollee requests the extension; or

2.a. The MCO demonstrates to the department that there is need for additional information; and

b. The extension is in the enrollee's interest.

(14) For an extension requested by an MCO, the MCO shall give the enrollee written notice of the reason for the extension.

(15) If an MCO denies a request for an expedited resolution of an appeal, the MCO shall:

(a) Transfer the appeal to the thirty (30) day timeframe for a standard resolution, in which the thirty (30) day period shall begin on the date the MCO received the original request for appeal;

(b) Give prompt oral notice of the denial; and

(c) Follow up with a written notice within two (2) calendar days of the denial.

(16) An MCO shall document in writing an oral request for an expedited resolution and shall maintain the documentation in the enrollee case file.

(17) If an MCO takes adverse action at the conclusion of an internal appeal process, the MCO shall issue an adverse action letter to the enrollee that complies with KRS 13B.050(3)(d) and (e).

(18)(a) The requirements and policies stated in this section regarding an MCO appeal shall apply to an MCO.

(b) If a requirement or policy regarding an appeal or an MCO appeal stated in another Kentucky administrative regulation within Title 907 of the Kentucky Administrative Regulations contradicts a requirement or policy regarding an MCO appeal that is stated in this section, the requirement or policy stated in the other administrative regulation shall not apply to an MCO.

Section 5. Department's State Fair Hearing for an Enrollee. (1) An enrollee may have a state fair hearing administered by the department in accordance with KRS Chapter 13B only after exhausting an MCO's internal appeal process.

(2) The department shall provide an enrollee with a hearing process that shall adhere to 907 KAR 1:563; 42 C.F.R. 438, Subpart F (438.400-438.424); and 42 C.F.R. 431, Subpart E (431.200-431.250).

(3)(a) An enrollee or authorized representative may request a state fair hearing by filing a written request with the department.

(b) If an enrollee or authorized representative requests a hearing, the request shall:

1. Be in writing and specify the reason for the request;

2. Indicate the date of service or the type of service denied; and

3. Be postmarked or filed within 120 calendar days from the date of the MCO adverse action letter issued at the conclusion of the MCO internal appeal process.

(4) A document supporting an MCO's adverse action shall be:

(a) Received by the department no later than five (5) calendar days from the date the MCO receives a notice from the department that a request for a state fair hearing has been filed by an enrollee; and

(b) Made available to an enrollee upon request by either the enrollee or the enrollee's legal counsel.

(5) An automatic ruling shall be made by the department in favor of an enrollee if an MCO fails to:

(a) Comply with the requirements of:

1. Section 4 of this administrative regulation; or

2. Subsection (4) of this section; or

(b) Participate in and present evidence at the state fair hearing.

Section 6. Enrollee Selection of Primary Care Provider. (1) Except for an enrollee described in subsection (2) of this section, an MCO shall have a process for enrollee selection and assignment of a primary care provider.

(2) The following shall not be required to have, but may request, a primary care provider:

(a) A dual eligible;

(b) A child in foster care;

(c) A child under the age of eighteen (18) years who is disabled;

(d) A pregnant woman who is presumptively eligible pursuant to 907 KAR 20:050; or

(e) An adult for whom the state is appointed a guardian.

(3)(a) For an enrollee who is not receiving supplemental security income benefits:

1. An MCO shall notify the enrollee within ten (10) calendar days of notification of enrollment by the department of the procedure for choosing a primary care provider; and

2. If the enrollee does not choose a primary care provider, an MCO shall assign to the enrollee a primary care provider who:

a. Has historically provided services to the enrollee; and

b. Meets the requirements of subsection (6) of this section.

(b) If no primary care provider meets the requirements of paragraph (a)2. of this subsection, an MCO shall assign the enrollee to a primary care provider who is within:

1. Thirty (30) miles or thirty (30) minutes from the enrollee's residence if the enrollee is in an urban area; or

2. Forty-five (45) miles or forty-five (45) minutes from the enrollee's residence if the enrollee is in a rural area.

(4)(a) For an enrollee who is receiving supplemental security income benefits and is not a dual eligible, an MCO shall notify the enrollee of the procedure for choosing a primary care provider.

(b) If an enrollee has not chosen a primary care provider within thirty (30) calendar days, an MCO shall send a second notice to the enrollee.

(c) If an enrollee has not chosen a primary care provider within thirty (30) calendar days of the second notice, the MCO shall send a third notice to the enrollee.

(d) If an enrollee has not chosen a primary care provider within thirty (30) calendar days after the third notice, the MCO shall assign a primary care provider.

(e) Except for an enrollee who was previously enrolled with the MCO, an MCO shall not automatically assign a primary care provider within ninety (90) calendar days of the enrollee's initial enrollment.

(5)(a) An enrollee may select from at least two (2) primary care providers within an MCO's provider network.

(b) At least one (1) of the two (2) primary care providers referenced in paragraph (a) of this subsection shall be a physician.

(6) A primary care provider shall:

(a) Be a licensed or certified health care practitioner who functions within the provider's scope of licensure or certification, including:

1. A physician;

2. An advanced practice registered nurse;

3. A physician assistant; or

4. A clinic, including a primary care center, federally qualified health center, federally qualified health center look-alike, or rural health clinic;

(b) Have admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges;

(c) Agree to provide twenty-four (24) hours a day, seven (7) days a week primary health care services to enrollees; and

(d) For an enrollee who has a gynecological or obstetrical health care need, a disability, or chronic illness, be a specialist who agrees to provide or arrange for primary and preventive care.

(7) Upon enrollment in an MCO, an enrollee may change primary care providers:

(a) Within the first ninety (90) calendar days of assignment;

(b) Once a year regardless of reason;

(c) At any time for a reason approved by the MCO;

(d) If, during a temporary loss of eligibility, an enrollee loses the opportunity provided by paragraph (b) of this subsection;

(e) If Medicare or Medicaid imposes a sanction on the PCP;

(f) If the PCP is no longer in the MCO provider network; or

(g) At any time with cause, which shall include the enrollee:

1. Receiving poor quality of care;

2. Lacking access to providers qualified to treat the enrollee's medical condition; or

3. Being denied access to needed medical services.

(8) A PCP shall not be able to request the reassignment of an enrollee to a different PCP for the following reasons:

(a) A change in the enrollee's health status or treatment needs;

(b) An enrollee's utilization of health services;

(c) An enrollee's diminished mental capacity; or

(d) Disruptive behavior of an enrollee due to the enrollee's special health care needs unless the behavior impairs the PCP's ability to provide services to the enrollee or others.

(9) A PCP change request shall not be based on race, color, national origin, disability, age, or gender.

(10) An MCO may approve or deny a primary care provider change.

(11) An enrollee shall be able to obtain the following services outside of an MCO's provider network:

(a) A family planning service in accordance with 42 C.F.R. 431.51;

(b) An emergency service in accordance with 42 C.F.R. 438.114;

(c) A post-stabilization service in accordance with 42 C.F.R. 438.114 and 42 C.F.R. 422.113(c); or

(d) An out-of-network service that an MCO is unable to provide within its network to meet the medical need of the enrollee in accordance with 42 C.F.R. 438.206(b)(4) subject to any prior authorization requirements of the MCO.

(12) An MCO shall:

(a) Notify an enrollee within:

1. Thirty (30) calendar days of the effective date of a voluntary termination of the enrollee's primary care provider; or

2. Fifteen (15) calendar days of an involuntary termination of the enrollee's primary care provider; and

(b) Assist the enrollee in selecting a new primary care provider.

Section 7. Member Handbook. An MCO shall send a member handbook to an enrollee as required by 42 C.F.R. 438.10.

Section 8. Enrollee Non-Liability and Liability for Payment. (1)(a) Except as specified in Section 9 of this administrative regulation, an enrollee shall not be required to pay for a medically necessary covered service provided by the enrollee's MCO.

(b) An enrollee may be liable for the costs of services received during an appeal process in accordance with:

1. 42 C.F.R. 431.230; or

2. 42 C.F.R. 438.404.

(2) An MCO shall not impose cost sharing on an enrollee greater than the limits established by the department in 907 KAR 1:604.

Section 9. Recoupment of Payment from an Enrollee for Fraud, Waste, or Abuse. (1) If an enrollee is determined to be ineligible for Medicaid through an administrative hearing or adjudication of fraud by the CHFS OIG, the department shall recoup a capitation payment it has made to an MCO on behalf of the enrollee.

(2) An MCO shall request a refund from the enrollee referenced in subsection (1) of this section of a payment the MCO has made to a provider for the service provided to the enrollee.

(3) If an MCO has been unable to collect a refund referenced in subsection (2) of this section within six (6) months, the commonwealth may recover the refund from the enrollee.

Section 10. Third Party Liability and Coordination of Benefits. (1) Medicaid shall be the payer of last resort for a service provided to an enrollee.

(2) An MCO shall:

(a) Exhaust a payment by a third party prior to payment for a service provided to an enrollee;

(b) Be responsible for determining a legal liability of a third party to pay for a service provided to an enrollee;

(c) Actively seek and identify a third party liability resource to pay for a service provided to an enrollee in accordance with 42 C.F.R. 433.138; and

(d) Assure that Medicaid shall be the payer of last resort for a service provided to an enrollee.

(3) In accordance with 907 KAR 20:005 and KRS 205.624, an enrollee shall:

(a) Assign, in writing, to the MCO the enrollee's rights to a medical support or payment from a third party for a medical service paid for by the MCO; and

(b) Cooperate with an MCO in identifying and providing information to assist the MCO in pursuing a third party that may be liable for care or services.

(4) If an MCO becomes aware of a third party liability resource after payment for a service provided to an enrollee, the MCO shall seek recovery from the third party resource.

Section 11. Legal Guardians. (1) A parent, custodial parent, person exercising custodial control or supervision, or an agency with a legal responsibility for a child by virtue of a voluntary commitment or of an emergency or temporary custody order may act on behalf of an enrollee who is under the age of eighteen (18) years, a potential enrollee, or a former enrollee for the purpose of:

(a) Selecting a primary care provider;

(b) Filing a grievance or appeal; or

(c) Taking an action on behalf of the child regarding an interaction with an MCO.

(2)(a) A legal guardian who has been appointed pursuant to KRS 387.500 to 387.800 may act on behalf of an enrollee who is a ward of the commonwealth.

(b) A person authorized to make a health care decision pursuant to KRS 311.621 to 311.643 may act on behalf of an enrollee, potential enrollee, or former enrollee in making the health care decisions.

(c) An enrollee may:

1. Represent the enrollee; or

2. Use legal counsel, a relative, a friend, or other spokesperson.

Section 12. Enrollees with Special Health Care Needs. (1)(a) In accordance with 42 C.F.R. 438.208, the following shall be considered an individual with a special health care need:

1. A child in or receiving foster care or state-funded adoption assistance;

2. A homeless individual;

3. An individual with a chronic physical or behavioral illness;

4. A blind or disabled child;

5. An individual who is eligible for SSI benefits; or

6. An adult who is a ward of the Commonwealth in accordance with 910 KAR Chapter 2.

(b) In accordance with 42 C.F.R. 438.208, an MCO shall:

1. Have a process to target enrollees for the purpose of screening and identifying those with special health care needs;

2. Assess each enrollee identified by the department as having a special health care need to determine if the enrollee needs case management or regular care monitoring;

3. Include the use of appropriate health care professionals to perform an assessment; and

4. Have a treatment plan for an enrollee with a special health care need who has been determined, through an assessment, to need a course of treatment or regular care monitoring.

(c)1. An enrollee who is a child in foster care shall be enrolled with an MCO through a service plan that shall be completed for the enrollee by DCBS prior to being enrolled with the MCO.

2.a. The service plan referenced in subparagraph 1. of this paragraph shall be used by DCBS and the MCO to determine the enrollee’s medical needs and to identify if there is a need for case management.

b. The MCO shall be available to meet with DCBS at least quarterly to discuss the health care needs of the child as identified in the service plan. The child's caretaker may attend each meeting held to discuss the health care needs of that child.

c. If a service plan identifies the need for case management or DCBS requests case management for an enrollee, the foster parent of the child or DCBS shall work with the MCO to develop a case management plan of care.

d. The MCO shall consult with DCBS prior to developing or modifying a case management plan of care.

e. If the service plan accomplishes a requirement stated in paragraph (b) of this subsection, the requirement stated in paragraph (b) shall be considered to have been met.

(2) A treatment plan referenced in subsection (1)(b)4. of this section shall be developed:

(a) With participation from the enrollee or the enrollee’s legal guardian as referenced in Section 11 of this administrative regulation; and

(b) By the enrollee’s primary care provider, if the enrollee has a primary care provider.

(3) An MCO shall:

(a)1. Develop materials specific to the needs of an enrollee with a special health care need; and

2. Provide the materials referenced in subparagraph 1. of this paragraph to the enrollee, caregiver, parent, or legal guardian;

(b) Have a mechanism to allow an enrollee identified as having a special health care need to directly access a specialist, as appropriate, for the enrollee's condition and identified need; and

(c) Be responsible for the ongoing care coordination for an enrollee with a special health care need.

(4) The information referenced in subsection (3)(a) of this section shall include health educational material to assist the enrollee with a special health care need or the enrollee's caregiver, parent, or legal guardian in understanding the enrollee's special need.

(5)(a) An enrollee who is a ward of the commonwealth shall be enrolled with an MCO through a service plan that shall be completed for the enrollee by DAIL prior to being enrolled with the MCO.

(b) If the service plan referenced in paragraph (a) of this subsection identifies the need for case management, the MCO shall work with DAIL or the enrollee to develop a case management plan of care.

Section 13. Second Opinion. An enrollee may get a second opinion within the MCO's provider network for a surgical procedure or diagnosis and treatment of a complex or chronic condition.

Section 14. Managed Care Requirements. (1) All aspects of managed care shall be governed and controlled by the applicable federal and state laws, including 42 C.F.R. Part 438, 42 U.S.C. 1396n, and 42 U.S.C. 1396u-2, and the negotiated terms of the contract between a managed care organization and the department.

(2) The current MCO contracts shall be posted on the department's Web site at https://chfs.ky.gov/agencies/dms/dpqo/Pages/mco-contracts.aspx [~~http://chfs.ky.gov/dms/contracts.htm~~].

Section 15. Centers for Medicare and Medicaid Services Approval and Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies or does not provide federal financial participation for the policy; or

(2) Disapproves the policy.

LISA LEE, Commissioner
ERIC FRIEDLANDER, Secretary

APPROVED BY AGENCY: October 26, 2021

FILED WITH LRC: November 12, 2021 at 8:00 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on January 24, 2022, at 9:00 a.m. using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor the week prior to the scheduled hearing. Individuals interested in attending this virtual hearing shall notify this agency in writing by January 14, 2022, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends virtually will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation until January 31, 2022. Send written notification of intent to attend the public hearing or written comments on the pro-

posed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-6746; fax 502-564-7091; email CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Persons: Jonathan Scott and Krista Quarles

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the managed care organization requirements and policies relating to individuals enrolled with a Medicaid managed care organization.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with KRS 205.520(3), 42 U.S.C. 1396n(b), and 42 C.F.R. Part 438.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing the managed care organization requirements and policies relating to individuals enrolled with a Medicaid managed care organization.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendment to this administrative regulation removes references to the Medicaid Works program to reflect the ending of that program. Medicaid Works recipients are being transferred into the expansion Medicaid population. In addition, a website link has been updated.

(b) The necessity of the amendment to this administrative regulation: This amendment to this administrative regulation is necessary to reflect the ending of the Medicaid Works program, and to update a technical reference to a website.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care.

(d) How the amendment will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by removing a reference to a discontinued program.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Since the creation of the Medicaid Works program in 2007, only 15 different people have ever used it. Currently, there are only 5 beneficiaries using the program, and DMS intends to otherwise accommodate this population within the existing healthcare system.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: There are not any actions that regulated entities will have to take to comply with this amendment that are not already required by the negotiated terms of the MCO contracts.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There are not any costs to complying with the changes to this administrative regulation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): DMS anticipates that current beneficiaries will remain in the Medicaid Program.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: The department anticipates no additional costs in the implementation of this administrative regulation.

(b) On a continuing basis: The department anticipates no additional costs in the continuing operation of this administrative regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Sources of funding to be used for the implementation and enforcement of 907 KAR Chapter 17 are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and agency appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: An increase in fees or funding is not necessary to implement this amendment.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does not establish any fees or directly or indirectly increase any fees.

(9) Tiering: Is tiering applied? Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438

2. State compliance standards. KRS 194A.010(1), 194A.025(3), 194A.030(2), 194A.050(1), 205.520(3), and 205.560

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the managed care organization requirements and policies relating to individuals enrolled with a Medicaid managed care organization.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this administrative regulation does not impose stricter, additional, or different requirements or responsibilities than those required by the federal mandate.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This administrative regulation does not impose stricter, additional, or different requirements or responsibilities than those required by the federal mandate.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Cabinet for Health and Family Services, Department for Medicaid Services

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.010(1), 194A.025(3), 194A.030(2), 194A.050(1), 205.520(3), 205.560, 42 U.S.C. 1396n(b), 42 C.F.R. Part 438.

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS does not anticipate that this administrative regulation will generate additional revenue for the state or local government in the first year.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS does not anticipate that this administrative regulation will generate additional revenue for the state or local government in subsequent years.

(c) How much will it cost to administer this program for the first year? DMS does not anticipate additional costs in administering this program in the first year.

(d) How much will it cost to administer this program for subsequent years? DMS does not anticipate additional costs in administering this program in subsequent years.

Revenues (+/-):

Expenditures (+/-):

Other Explanation: